

TRANSACTIONS
OF THE
NEW YORK SURGICAL SOCIETY.

Stated Meeting, Wednesday, December 9, 1903.

The President, HOWARD LILIENTHAL, M.D., in the Chair.

INTESTINAL OBSTRUCTION FOLLOWING APPENDICITIS.

DR. LUCIUS W. HOTCHKISS presented a man, fifty-four years old, who was admitted to the J. Hood Wright Hospital October 23, 1903, with the usual signs of an acute, progressing appendicitis. His past history was negative, with the exception of the fact that he had been addicted to the rather free use of alcoholic stimulants. Three days prior to his admission he began to suffer from an acute pain in the right iliac region, which gradually increased in severity. He had vomited a number of times and had been unable to retain any nourishment. Upon admission, his temperature was 102° F.; pulse, 120; respirations, 32. Four hours after his arrival at the hospital he was placed on the operating table. Under gas and ether anaesthesia an incision was made to the outer side of McBurney's point, through which a small amount of sero-sanguineous fluid and about half an ounce of thick pus escaped. The appendix, which was about five inches long and bound down by numerous adhesions, was freed and excised in the usual way, and the stump invaginated. After washing out the wound with peroxide of hydrogen and salt solution, a cigarette drain was inserted and the wound closed in layers about the drain. Upon examination, the proximal end of the appendix was found to be gangrenous, while its distal half was considerably inflamed: it contained a blood-clot and pus.

The patient had taken the ether badly, and became very noisy and troublesome at the completion of the operation. He devel-

oped a delirium which lasted for several days, and required constant restraint. While in this condition he succeeded on one occasion in getting out of bed. Four days after the operation he was again perfectly rational. There was a slight discharge from the granulating wound. He continued to improve, and on November 7 he was able to sit up for a short time. On this day he began to complain of pain in the rectum, with a constant inclination to defecate, although his bowels had not moved in thirty-six hours. The pain in the rectum persisted, and an examination revealed a soft, fluctuating mass bulging into the anterior wall of the bowel, about three inches above the sphincter. There was also tenderness above the pubes.

On November 8 Dr. Chase, the assistant surgeon, made a median incision below the umbilicus, and found the intestines matted together into a large mass. The bladder could not be recognized at first, but upon inserting a sound, it was found to the right of this mass, bound down by adhesions. Upon attempting to free it a large abscess cavity occupying Douglas's pouch was opened, followed by a free escape of very foul-smelling pus and flakes of fibrin. When the bladder was freed, it immediately resumed its normal position. The adherent loops of intestine were freed as far as possible, and in doing this numerous small pockets of pus were evacuated. The abdomen was thoroughly irrigated with saline solution, and a large cigarette drain inserted leading down into Douglas's pouch. On the following day the patient had a free movement of the bowels. His further recovery was uninterrupted, and he was discharged from the hospital on December 4.

DR. WILLY MEYER referred to a similar case coming under his care. Eleven days after an operation for perforative appendicitis the patient developed all the classical symptoms of intestinal obstruction, and upon reopening the abdomen he came down upon a mass of matted intestine and omentum. Upon separating the adhesions he again heard the peculiar gurgling sound indicating intestinal obstruction, and upon further investigation he found in the left lumbar region an abscess containing a large amount of stinking pus. This was evacuated and drained. The intestinal obstruction promptly disappeared and the patient eventually made a perfect recovery.

DR. F. KAMMERER said the cause of the intestinal obstruction

described by Dr. Hotchkiss was certainly a very rare one. It was at times difficult to differentiate between intestinal obstruction and a well-developed peritonitis, with symptoms of obstruction. Even if peritonitis was not general, such symptoms might be present. That a circumscripted collection of pus, however, should give rise to acute intestinal obstruction in a mechanical way he was somewhat loth to believe. It rather seemed to him that after evacuation of the abscess such mechanical disturbances might arise.

DR. WILLY MEYER said that in his case there was no reason to suspect that the obstruction was a retroperistalsis due to acute peritonitis; for eleven days had elapsed since the operation and the patient was practically well when the symptoms of obstruction suddenly intervened. The speaker said he did not attribute the obstruction to the presence of the abscess, but to a kink of the matted intestines that formed the wall of the same.

DR. LILIENTHAL said he thought the mere fact that pus was present had nothing to do with the case. The important factor was the mass of adhesions, which in the cases reported by Drs. Hotchkiss and Meyer happened to form the wall of an abscess. Adhesions resulting from anything else might likewise give rise to obstruction.

DR. HOTCHKISS said that a few years ago he had read a paper before the Society in which he reported three cases of obstruction following appendicitis occurring in the course of his own work, and also a number of cases observed by others. It seemed to him that these cases may be divided into two classes: First, those in which the obstruction occurs in the afebrile period, that is to say, from two or three weeks to two or three months or longer after the original operation. These cases are easily to be recognized, and are due either to kinking of the gut by adhesions or its strangulation by bands. The second class embraces those cases which come on soon after operation, or as early as the second or third or fourth day later, that is, during the afebrile period, and which are generally regarded as cases of extending peritonitis, which are not operated upon, and are generally fatal. These latter cases, which are often masked by symptoms of peritonitis, he regarded as the most dangerous because they are most often unrecognized. That these cases can be successfully dealt with by prompt operative measures he thought had been abundantly demonstrated.

GASTRODUODENOSTOMY (FINNEY'S METHOD).

DR. HOWARD LILIENTHAL presented a man, forty-two years old, who was admitted to Mt. Sinai Hospital on May 21, 1903. He had been sick for three years with constantly increasing abdominal discomfort, associated with vomiting. The vomited matter consisted principally of mucus and food, never blood. The patient's symptoms gradually became more aggravated. He became emaciated, and a physical examination of the chest revealed dulness over both apices. Tubercle bacilli were found in the sputum.

An examination of the stomach contents revealed the presence of free hydrochloric acid, and after further observation a diagnosis of benign stenosis of the pylorus was made. May 23 gastro-duodenostomy by the Finney method was done, and the wound was closed with a cigarette drain. The next day the man vomited some blood and his temperature was slightly elevated. There were no other untoward symptoms, and six days after the operation the man was allowed solid food. He was discharged June 13 entirely well. Since then he had gained sixty pounds in weight, and his pulmonary and abdominal symptoms had entirely disappeared.

RESECTION OF PYLORUS FOR BENIGN STENOSIS.

DR. FREDERICK KAMMERER presented a woman, fifty-three years old, who had been under treatment since last summer for gastric trouble which dated back to May of the present year. She had been under the care of various physicians. She complained of all sorts of gastric disturbances, including sour taste, eructations of gas, vomiting, etc.; in short, symptoms of gradually increasing stenosis of the pylorus. When the speaker first saw her, about two or three months ago, she presented the typical picture of pyloric stenosis. The stomach was dilated, reaching midway between the umbilicus and symphysis. She vomited frequently, and when her stomach was washed out particles of food that had been introduced two or three days before were found. Peristaltic movements of the stomach were readily visible through the abdominal walls. At a previous examination, before her admission to the hospital, lactic acid and hydrochloric acid in small quan-

tities were found in the stomach contents; but when the latter were examined at the hospital, two months later, hydrochloric acid was absent. To the left of the umbilicus a freely movable, hard tumor, about the size of a walnut, was distinctly made out through the lax abdominal wall. A blood examination showed between 40 and 45 per cent. of haemoglobin.

Through a median incision the stomach was exposed and a tumor about the size of a small egg was found involving the pylorus. A resection was done by the usual method, removing the entire lesser curvature and at least one-half of the greater curvature far beyond the actual site of the growth. Instead of employing Kocher's clamps, as he usually did in these operations, Dr. Kammerer said he used Mikulicz's clamp on this occasion. About one inch of the duodenum was also removed. The open ends of the stomach and the duodenum were now closed by a double running suture of silk, and a posterior antecolic gastro-enterostomy performed, the parts being easily approximated without the slightest tension. A Murphy button was used. The patient made a good recovery. The button passed on the eleventh day. A microscopic examination of the growth showed it to be purely fibrous. In the course of the operation two infiltrated glands were found and removed,—one was located in the lesser and one in the greater omentum. The case illustrates the difficulties of an accurate diagnosis between malignant or benign stenosis in some cases.

CHRONIC PANCREATITIS.

DR. KAMMERER presented a woman, forty-eight years old, who had enjoyed good health up to eight weeks before her admission to the hospital. She gave no history of jaundice or malaria, but had had repeated attacks of rheumatism. For the past eight weeks she had suffered from pain in the epigastrium, general gastric distress, and occasional vomiting. About a fortnight before her admission her symptoms became more acute, and she suffered from severe pain in the abdomen and lumbar region and in the legs. Her appetite was poor; she had constant headaches and felt feverish. At about this time jaundice appeared and had persisted since.

When she came to the hospital, October 14 of the present year, the jaundice was very marked, but otherwise the examination proved entirely negative. She was kept under observation for several weeks, during which time she became more deeply jaundiced, and in order to clear up the diagnosis an exploratory operation was done October 26. The gall-bladder was found to be of normal thickness but somewhat enlarged and filled with bile. No stones could be detected. The common duct was thoroughly exposed by incising the peritoneum to the outside of the duodenum and entering the retroduodenal space, but nothing abnormal was found. The surface of the liver was slightly nodular, and the possibility of a beginning cirrhosis suggested itself. Upon examining the pancreas, a distinct tumor in the head of that organ was made out. It was about the size of a small egg and clearly outlined. A cholecystoduodenostomy was done, when, upon opening the duodenum, a large amount of bile escaped into the intestine, showing that the obstruction, which was apparently due to the tumor in the head of the pancreas, had been at least momentarily overcome (most probably by manipulation with the gall-bladder). The patient made an uneventful recovery from the operation, and has improved wonderfully since. The jaundice gradually disappeared and has not reoccurred.

Dr. Kammerer said he regarded the case as one of chronic pancreatitis which had been relieved by the operation. Whether it would have been wiser to do a simple cholecystotomy was an open question.

In reply to a question as to whether he followed the common bile duct as it entered the head of the pancreas, Dr. Kammerer said he was satisfied that it contained no stone.

DR. WILLY MEYER said he had a similar case about three years ago. The patient was also a female, with pronounced jaundice. No stone was found; nothing but this infiltration involving the head of the pancreas. He did a cholecystostomy, which resulted in quite a troublesome fistula, but the wound finally closed permanently. Dr. Meyer said that in the treatment of this class of cases he would perhaps try first a cholecystostomy, and that failing, he would resort to permanent union between the gall-bladder and intestinal tract.

GASTRO-ENTEROSTOMY WITH ENTERO-ENTEROSTOMY
(ELASTIC LIGATURE).

DR. WILLY MEYER presented a man, sixty years old, who had had an intestinal haemorrhage in 1894, and after its occurrence he began to complain of symptoms of chronic gastritis. These were not serious enough to interfere with his business until one year ago, when, while travelling abroad, he had a fainting spell and vomited. The vomited matter did not contain any blood, but on the following day he had a large, tar-like stool. From this attack he slowly recovered, and afterwards all his former gastric symptoms increased in severity. He was treated by a number of specialists, both here and abroad, who washed out the stomach and advised against operative interference.

In August, 1903, he had a third intestinal haemorrhage. He became much reduced in weight and strength, and finally consented to an exploratory operation. The specialist who had been consulted abroad thought the lesion was an ulcer of the pylorus, but when the patient was admitted to the German Hospital in this city, a chronic ulcer of the duodenum was regarded as the probable diagnosis.

Upon opening the abdomen, nothing was found on the anterior or posterior stomach wall nor at the pylorus, but a thickened area in the duodenal wall could be distinctly made out. A posterior gastro-enterostomy was thereupon done by the McGraw (elastic ligature) method, the No. 3 ligature being employed. In uniting the stomach and small intestine, a continuous suture was used, and this gave rise to so much tension later, when tightening the ligature, that a tear in the stomach wall occurred. This was immediately closed with four interrupted sutures. In order to avoid the formation of a vicious circle, an additional entero-enterostomy was done also by means of the elastic ligature.

The patient made an uninterrupted recovery, and was given liquid nourishment by the stomach at the end of forty-eight hours. He had a few attacks of vomiting shortly after the operation, but was able to leave his bed in five weeks. Since the operation he had gained over twenty-five pounds in weight, and had had no further gastric symptoms.